Quick Guide:
2nd Trimester Terminations

Admission

- Ask if they have a birth plan
  - If it was known, there should be a copy in the Charge binder
  - If new diagnosis, ask about preferences
    - "During this process, how would you like us to refer to your baby?"
    - "Would you want to see them? Would you want to hold them?"
      - If yes:
        - "Would you want to do skin to skin immediately after delivery, or have us clean and dry baby off at the warmer first?"
        - "Would you like to bathe your baby, or would you like us to do it?"
    - Start considering disposition (private burial/cremation? genetic testing? autopsy?)
- Offer pastoral care/chaplaincy and social work/community resources
- Admission as usual: vital signs, IV + labs, admission flowsheet tabs, required docs, education, care plan
  - Additionally, you will need to fill out the Bereavement flowsheet tab
- Double check consent forms
- Use door signage for perinatal loss

Induction

With 2nd trimester terminations (13.0-28.0 wks gestation), we induce with misoprostol **OR** high-dose oxytocin. ***They should not be administered simultaneously before birth.**** Misoprostol regimen is often preferred due to the relative scarcity of oxytocin receptors in this gestational period. Mifepristone may be given prior to either.

Misoprostol Induction

- For **13.0-26.0** wks gestation:
  - Option 1: **With** loading dose
    - 800mcg vaginal → followed by 400mcg vaginal, buccal, or sublingual q3 hrs
  - Option 2: **Without** loading dose
    - 400mcg vaginal, buccal, or sublingual q3 hrs
- For **26.1-28.0** wks gestation:
  - 50mcg vaginal, buccal, or sublingual q4

High Dose Oxytocin Induction

- Utilizes **high concentration** oxytocin bag (200 units in 500 mL)
  - Pharmacy will prepare once ordered
  - RN must pick up from pharmacy
- Set up IV line w/ carrier fluid and stopcock as usual
- For **13.0-26.0** wks gestation:
  - Administer oxytocin at 20 units/hr
- For **26.1-28.0** wks gestation:
  - Administer oxytocin at 10 units/hr

- Ask pt to void prior to insertion of vaginal miso-- 1 hr bedrest after each dose
- Monitor toco for at least 30 mins prior to each repeat dose

- Note **units** not milliunits when programming pump
- Monitor toco and document every hour

Hourly documentation: V/S, pain, vaginal bleeding, I/Os, uterine activity as ordered

Providers may decide to change the induction regimen from misoprostol to high-dose oxytocin. If so, there must be **at least 4 hours between the last dose of misoprostol and the initiation of oxytocin for induction.

There will be a standing STAT PRN order for ***postpartum*** high dose oxytocin (200 units in 500mL bag) for the possibility that the fetus delivers ***but the placenta does not.*** The pharmacy will prepare this medication once ordered, and the RN should pick up and have ready **prior to delivery of the fetus**.

Pain Management Options

- **PO**: Tylenol & Motrin
- **IV**: Toradol, IV push narcotics, IV PCA
- **Epidural**

Delivery Documentation

Fetus **< 20 wks** gestation

- Document loss in patient's obstetrical history (LD Navigator tab → Triage → OB History)
- Write a nursing note with delivery time of fetus and placenta + any other pertinent info

Fetus **≥ 20 wks** gestation

- Pend baby chart and document details in Delivery Summary

After Delivery of the Fetus

If the placenta delivers, administer typical postpartum oxytocin (30 units in 500mL bag).

If the fetus delivers ***but the placenta does not***, administer postpartum **high-dose** oxytocin (200 units in 500mL bag) as ordered. It is ONLY to be administered postpartum for this indication. If the induction was already utilizing high dose oxytocin, the infusion will simply continue.

If the placenta has not delivered within **30 minutes** of delivery of the fetus, the providers may (1) continue high dose oxytocin for **up to 2 hours**, (2) give additional medications like misoprostol, and/or (3) perform manual extraction/D&C. If proceeding with a D&C, administer pre-op antibiotics as ordered. If the placenta is not out after 2 hours, the providers should re-evaluate for further management.

After the placenta delivers, administer typical postpartum oxytocin (30 units in 500mL bag) and implement typical vaginal delivery or D&C recovery protocol.

Bereavement considerations: Mementos/memory box, save clothes/blankets, Now I Lay Me Down to Sleep (NILMDS)

Helpful Policies

- *Fetal Death Procedures* (L&D110)
  - Reviews **death paperwork**, fetus and placenta **disposition** to morgue or pathology
- *High Dose Oxytocin for Second Trimester Termination, Management of Patient Receiving* (OBMED-E208)
- *Misoprostol (Cytotec) for Second Trimester Termination, Management of Patient Receiving* (OBMED-E220)